STATE OF HAWAII
DEPARTMENT OF HEALTH
4348 Waialae Avenue, #648
Honolulu, Hawaii 96816

APPLICATION #_____

Medical Use of Marijuana Minor Certification

SECTION B. *This section to be signed by the parent, guardian or legal custodian of a minor applicant.*

Minor Applicant's NAME:

_____
Last First Middle

Note: Please use the minor's name EXACTLY as it appears on their VALID government identification or Birth Certificate.

I am the: ■ **Parent** **OR** □ **Guardian** **OR** □ **Legal Custodian** *(mark one)*

I CERTIFY that:

□ Yes □ No I am the parent, guardian, or legal custodian of the above mentioned minor qualifying patient; and

□ Yes □ No I have legal authority to make health care decisions on behalf of the minor qualifying patient; or

□ Yes[1] □ No I share joint legal authority to make health care decisions on behalf of the minor qualifying patient with _____
(name of individual with whom you share joint legal authority)

For Joint Legal Authority, both must initial below:

(initial)	*(initial)*	The minor's primary care physician, so named on this application, has explained the potential risks and benefits of the medical use of marijuana to me and the minor qualifying patient.
(initial)	*(initial)*	I consent to allow the minor qualifying patient to use medical marijuana.
(initial)	*(initial)*	I consent to serve as the primary caregiver for the minor patient/applicant.
(initial)	*(initial)*	I agree to control the acquisition, possession, dosage, and frequency of the medical use of marijuana by the minor patient/applicant.
(initial)	*(initial)*	I consent to allow the minor qualifying patient's primary care physician, so named in this application, to release any protected health information pertaining to the minor qualifying patient's debilitating medical condition for the purpose of the registration for medical use of marijuana as set forth in part IX, chapter 329, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of the minor qualifying patient's medical use of marijuana registration card or upon my written revocation of this consent. I understand that if I revoke my consent, the minor qualifying patient's medical use of marijuana registration card will be revoked.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that the minor qualifying patient's registration as a qualified patient to use medical marijuana under Hawaii law may not protect me or the minor qualifying patient against arrest, prosecution, or conviction under Federal law.

Print Name of Parent, Guardian, or Legal Custodian that will act as CAREGIVER for the Minor Applicant	For *JOINT LEGAL CUSTODY* Print *second* Parent, Guardian, or Legal Custodian's Name
Signature of Parent, Guardian, or Legal Custodian DATE	Signature of *second* Parent, Guardian, or Legal Custodian DATE

[1] *If this box is checked, both persons with legal authority to make health care decisions MUST initial the applicable items and sign this section.*